CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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July 26, 2010

TO: Hospital Providers (01)
Provider Letter #A-244

RE: Hospital Acquired Conditions (HACs)

Dear Kentucky Medicaid Provider:

In 2008, the Centers for Medicare & Medicaid Services (CMS) "encouraged" Medicaid programs to develop policies for when hospital providers bill for preventable hospital-acquired conditions ("HACs") including some conditions on the National Quality Forum's ("NQF") list of Serious Reportable Events (referred to as "Never Events"). In a July 31, 2008 letter to State Medicaid Directors, CMS described these Never Events as "errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization".

With the passing of the Patient Protection and Affordable Care Act of 2010, states are now required to implement HAC policies. The Act specifically requires CMS to identify State Medicaid policies that prohibit payment for select HACs. The Act also requires that CMS incorporate HAC payment policies into Medicaid program regulations by July 1, 2011 that "prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations." As such, states must implement a HAC payment reduction policy or risk losing Federal match for Medicaid payments.

In an effort to comport with CMS's directive, the Department for Medicaid Services will, effective July 1, 2010, require that all hospital claims filed on behalf of any Medicaid recipient include all data necessary to assist in identifying these conditions. The following items will be required on all claims for dates of discharge beginning July 1, 2010: Use of the Present on Admission Indicator. The POA Indicator shall be keyed into the 8th position for each diagnosis code. This Indicator and the Diagnosis will be reviewed in combination to create either a payment or a suppression of payment.

Upon submission, claims will be adjudicated with pricing logic to suppress secondary diagnosis codes when, in the absence of a POA indicator, they indicate a CMS Hospital Acquired Condition when assigning DRGs using the current grouper. Your compliance with this request is mandatory to ensure appropriate claims payment.

Sincerely,

Elizabeth A. Johnson
Commissioner

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